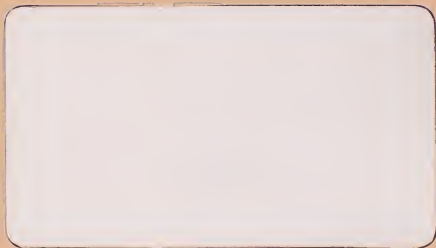


Health Care Financing RESEARCH BRIEF

**These brief reports from the
Office of Research, Office of
Research and Demonstrations, provide
Medicare and Medicaid program information
on current health care issues.**

**They are based on data from
the Medicare statistical files
developed and maintained by the
Bureau of Data Management
and Strategy, Health Care
Financing Administration**

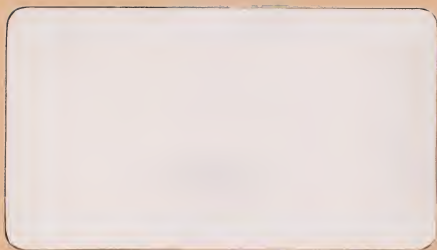


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Health Care Financing Administration
Office of Research and Demonstrations



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Research Brief No. 87-5
Medicaid: Use and Cost of Services,
Fiscal Year 1985

Medicaid: Use and Cost of Services, Fiscal Year 1985

General

The purpose of this Brief is to provide an overview of Medicaid (Title XIX of the Social Security Act) program data on recipients of medical care and payments made for services furnished during fiscal year (FY) 1985. Data for FY 1984 are also presented.

Medicaid is a federally authorized public assistance program that provides medical care for eligible low-income individuals and families. Funded jointly by Federal and State governments, Medicaid is administered by the States under broad Federal requirements and guidelines. The guidelines allow each State considerable discretion in determining income and other resource criteria for eligibility, covered benefits, and provider payment mechanisms. For this reason, Medicaid is considered one of the most complex of all public assistance programs.

All States and the District of Columbia participate in the Medicaid program. Participating territories include Guam, Puerto Rico, Virgin Islands, American Samoa, and the Northern Mariana Islands. Arizona administers Medicaid under a Health Care Financing Administration (HCFA) demonstration project, and the data are not comparable to other States. Consequently, data for Arizona are not included in this report.

In FY 1985, the Medicaid program provided services to 21.8 million recipients at a combined Federal/State cost of \$37.5 billion. Hence, Medicaid accounted for over 10 percent of the Nation's personal health care expenditures (\$371.4 billion) during that period (Figure 1).

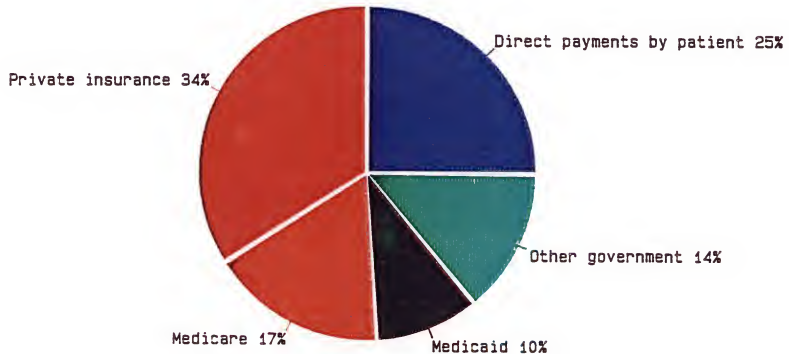
Eligibility

Medicaid plans must include individuals classified as mandatory categorically needy. These categories include:

- Recipients of Title IV-A: Aid to Families with Dependent Children (AFDC) or individuals deemed to be recipients of AFDC.
- Recipients of Title IV-E: Adoption Assistance and Foster Care.
- Recipients of Title XVI: Supplemental Security Income (SSI), or aged, blind, and disabled individuals who meet more restrictive requirements of eligibility.
- Pregnant women and children under age 5 who meet AFDC financial requirements.
- Special protected groups (generally individuals who lose cash assistance because of cash assistance program rules, but Medicaid is continued).

The State has the discretion also of providing Medicaid to individuals in optional eligibility groups (categorically needy and medically needy). Optional eligibility

Figure 1
Percent distribution of national personal health
care expenditures, by source of funds: Fiscal year 1985



Personal health care
expenditures - \$371.4 billion

SOURCE: Health Care Financing Administration, Office of the Actuary:
Data from the Office of National Cost Estimates.

groups share characteristics of the mandatory groups, but are more liberally defined. With certain specified exceptions, the income and resource requirements or methods of the most closely related cash assistance program (AFDC or SSI) are used to determine Medicaid eligibility for the categorically needy and medically needy, respectively.

Examples of optional eligibility groups are:

- Children up to age 21 with income and resources below cash assistance program limits.
- Pregnant women, children under age 5, and aged and disabled recipients with incomes or assets above the cash program limits but below the Federal poverty level.
- Recipients of optional State supplementary payments.
- Institutionalized individuals with incomes above the SSI limits.
- Individuals receiving care under home- and community-based waivers.
- Individuals who are classified as medically needy.

The medically needy option allows States to provide Medicaid to individuals and families who have more income and, in some instances, more resources than allowed for Medicaid under other eligibility groups. A feature of this option is that an individual or family having income in excess of a State's prescribed limit can reduce excess income by incurring medical expenses and can establish Medicaid eligibility (i.e., by spend down). If a State chooses the medically needy option, Medicaid services must be provided to:

- All pregnant women during the course of their pregnancy who, but for income and resources, would be eligible for Medicaid as categorically needy.
- Individuals under age 18 who would be eligible as mandatory categorically needy, but for income and resources.
- Blind and disabled individuals eligible as medically needy in December 1973 and who continue to meet the December 1973 criteria.

States may extend medical assistance to individuals who do not qualify for the Medicaid program. However, for these individuals, the Federal Government does not provide matching financial assistance to the States. These groups of individuals are referred to as "State-only."

For purposes of this report, individuals eligible for Medicaid are classified into two major maintenance-assistance status groups. Cash assistance recipients include those individuals in categorically needy groups who actually receive a cash payment under AFDC, SSI, Title IV-E, or through a State supplement. Medical-assistance only recipients include all other Medicaid eligibility groups.

Services

Title XIX of the Social Security Act requires that every State Medicaid program offer certain basic services (Appendix A). States receive Federal financial assistance for these basic services as well as other optional services they may elect to cover within the Federal Medicaid program (Appendix B).

Each State determines the scope and range of services to be covered under the State Medicaid program. The services must be sufficient in amount, duration, and scope to reasonably achieve their purpose. They must be provided to all residents of the State unless a waiver of this provision is granted under special Secretarial authority. Service limitations may be imposed by the State based on medical necessity and utilization review. For example, the State may limit the days of hospital care, the number of physician visits, or the number of outpatient visits. States may not impose arbitrary limits for mandatory services based on diagnosis, type of illness, or condition.

Many States have modified existing services through the use of home- and community-based services which offer a cost-effective alternative for people who would otherwise be institutionalized under Medicaid. States are not limited in the range of services they can provide, except that they may not provide room and board for such waived recipients.

Payments

Medicaid operates primarily as a vendor payment program. Payments are made directly by the State to providers of services (vendors) for medical care rendered to eligible individuals. Methods of reimbursing providers vary widely among States; however, providers must accept Medicaid reimbursement as payment in full. For example:

- For hospital, skilled nursing facility, and intermediate care facility services, States are required to provide for payment of services by the use of rates. These rates are developed by the State and, in the case of hospitals, take into account that some hospitals serve a disproportionate number of low-income patients with special needs. Also, the rates provide a lower level of reimbursement for hospital patients receiving services at an inappropriate level of care. For a closer look at the payment structure, see the Social Security Act, Section 1902(a)(13)(A).
- For physician services, States have broad discretion within general Federal guidelines regarding Medicaid reimbursement. State Medicaid programs can use either the Medicare formula for customary, prevailing, or reasonable charges, or a fee schedule approach.

The Federal share of State medical vendor payments is determined by the Federal Government according to the Medicaid Federal medical assistance percentages (FMAP) formula. The FMAP, in existence since the inception of the program, was established to determine the Federal payment to each State. FMAP is based on a formula designed to calculate the State share and the Federal share. The FMAP formula is as follows:

$$\text{State share} = \frac{(\text{State per capita income})}{(\text{National per capita income})} \times 45\%$$

$$\text{Federal share} = 100\% \text{ minus the State share}$$

By design, the formula sets higher rates of Federal matching (up to a statutory maximum of 83 percent) for States with relatively low per capita incomes and lower rates (to a minimum of 50 percent) for States with relatively high per capita incomes.

In FY 1985, the Federal share of Medicaid expenditures amounted to \$21 billion and the State's share was \$16.5 billion.

Medicaid is financed from several different sources including:

- Federal matching assistance payments.
- The Federal Government through the Medicare program for persons entitled to benefits under both programs.
- State governments.
- Local governments (in some States).
- Third parties who are otherwise liable for care provided to Medicaid eligibles.
- Medicaid recipients.

Cost sharing

States are permitted to require specified recipients to share some of the costs of Medicaid by imposing payments for enrollment fees, premiums, deductibles, coinsurance, copayments, or similar cost-sharing charges. Federal regulations specify standards and conditions for States to implement cost sharing, set forth minimum and maximum amounts, and describe limitations on the availability of Federal financial participation that relate to cost-sharing requirements. Individuals covered under the categorically needy program are never involved in cost sharing.

This Research Brief was prepared in the Division of Program Studies of the Office of Research. For additional information call Anthony Parker at (301) 597-1417 or FTS 987-1417 and Vikki Latta at (301) 597-1438 or FTS 987-1438. For suggestions regarding future topics, please call Charles R. Helbing at (301) 597-1420 or FTS 987-1420.

Selected data highlights

Table 1 – Medicaid recipients and payments, by basis of eligibility: Fiscal years 1984-85

- The total number of recipients increased from 21.6 million in FY 1984 to 21.8 million in FY 1985, an increase of 0.9 percent.
- The amount of total payments rose from \$33.9 billion in FY 1984 to \$37.5 billion in FY 1985, an increase of 10.7 percent. The rate of increase in payments during this period ranged from 7.4 percent for adults in families with dependent children to 14.1 percent for other Title XIX recipients.
- From FY's 1984 through 1985, the largest relative increase in the number of Medicaid recipients was for the disabled (3.6 percent). The payments for this eligibility group increased 12.3 percent from FY 1984 (\$11.8 billion) to FY 1985 (\$13.2 billion).

Table 2 – Medicaid recipients, payments, and payment per recipient, by basis of eligibility: Fiscal years 1984-85

- From FY's 1984 through 1985, the average Medicaid payment per recipient rose from \$1,569 to \$1,720, an increase of 9.6 percent. Average payments for the age 65 and over eligibility group showed the largest increase (16.4 percent), rising from \$3,957 to \$4,605.
- In FY 1985, the average Medicaid payment per recipient was nearly 8 times higher for the aged, blind, and disabled groups combined (\$4,533) than for the eligibility groups of adults in families with dependent children and dependent children under age 21 (\$600).

Table 3 – Medicaid recipients, payments, and percent distribution, by basis of eligibility: Fiscal year 1985

- Dependent children under age 21 (44.7 percent) and adults in families with dependent children (25.3 percent) together comprised 70.0 percent of all Medicaid recipients, but accounted for only 24.5 percent of all Medicaid payments (Figure 2).
- In contrast, the aged, blind, and disabled eligibility groups together comprised 27.9 percent of all Medicaid recipients, but accounted for 73.5 percent of the total Medicaid payments. The cost of services for these eligibility groups is high because the medical care they require is generally received in a hospital or nursing home.

Table 1

Medicaid recipients and payments, by basis of eligibility: Fiscal years 1984-85

Basis of eligibility	Recipients in thousands		Percent change 1984-85	Payments in millions		Percent change 1984-85
	1984	1985		1984	1985	
Total	21,607	21,808	0.9	\$33,891	\$37,508	10.7
Age 65 and over	3,238	3,061	-5.5	12,815	14,096	10.0
Blind	79	80	1.5	219	249	13.9
Disabled	2,834	2,936	3.6	11,758	13,203	12.3
Dependent children under age 21	9,684	9,752	0.7	3,979	4,414	11.0
Adults in families with dependent children	5,600	5,518	-1.5	4,420	4,746	7.4
Other Title XIX	1,187	1,214	2.3	700	798	14.1

NOTE: The sum of recipients exceeds total recipients because recipients who are eligible in more than one category are counted in each category, but only once in the total.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 2

Medicaid recipients, payments, and payment per recipient, by basis of eligibility: Fiscal years 1984-85

Basis of eligibility	1984		Payment per recipient	1985		Payment per recipient
	Recipients in thousands	Payments in millions		Recipients in thousands	Payments in millions	
Total	21,607	\$33,891	\$1,569	21,808	\$37,508	\$1,720
Age 65 and over	3,238	12,815	3,957	3,061	14,096	4,605
Blind	79	219	2,772	80	249	3,113
Disabled	2,834	11,758	4,149	2,936	13,203	4,497
Dependent children under age 21	9,684	3,979	411	9,752	4,414	453
Adults in families with dependent children	5,600	4,420	789	5,518	4,746	860
Other Title XIX	1,187	700	590	1,214	798	657

NOTE: The sum of recipients exceeds total recipients because recipients who are eligible in more than one category are counted in each category, but only once in the total.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 3

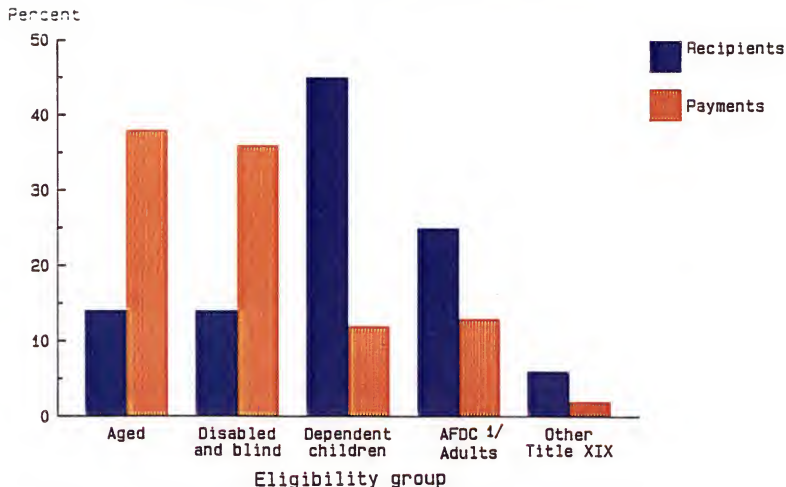
Medicaid recipients, payments, and percent distribution, by basis of eligibility: Fiscal year 1985

Basis of eligibility	Recipients in thousands	Payments in millions	Percent distribution	
			Recipients	Payments
Total	21,808	\$37,508	100.0	100.0
Age 65 and over	3,061	14,096	14.0	37.6
Blind	80	249	0.4	0.7
Disabled	2,936	13,203	13.5	35.2
Dependent children under age 21	9,752	4,414	44.7	11.8
Adults in families with dependent children	5,518	4,746	25.3	12.7
Other Title XIX	1,214	798	5.6	2.1

NOTE: The sum of recipients exceeds total recipients because recipients who are eligible in more than one category are counted in each category, but only once in the total.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Figure 2
Percent distribution of Medicaid recipients
and payments: Fiscal year 1985



1/ Adults receiving Aid to Families with Dependent Children.

NOTE: The sum of percentages by basis of eligibility may exceed 100 percent because a recipient may be counted in more than one eligibility group.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 4 - Percent distribution of Medicaid recipients and payment, and average payment per recipient, by maintenance assistance status and basis of eligibility: Fiscal year 1985

- An estimated 73.2 percent of all Medicaid recipients received cash assistance. This group accounted for 51.5 percent of all Medicaid payments, an average payment of \$1,210 per recipient.
- Conversely, 26.8 percent of all Medicaid recipients received medical assistance only. They accounted for 48.5 percent of all Medicaid payments, an average payment of \$3,113 per recipient.
- The aged, blind, and disabled eligibility groups receiving medical assistance only had the highest average payment per recipient, nearly 3 times higher than the average payment for the identical groups receiving cash assistance.
- In contrast, for dependent children under age 21 and adults in families with dependent children, the average payment per recipient was slightly higher for the cash assistance group (\$609) than for the medical assistance group (\$560) (Data are not shown on the table).

Table 5 - Medicaid recipients, payments, percent of payments, and payment per recipient, by type of service: Fiscal year 1985

- Of all Medicaid payments, 30 percent was for intermediate care facility services. Inpatient hospitals and skilled nursing facilities accounted for another 28 percent and 14 percent, respectively. These payments for institutional care accounted for 72 percent (\$27.0 billion) of all Medicaid payments (Figure 3).
- The average payment for ICF/MR services (\$32,320) was nearly 19 times higher than the overall average Medicaid payment per recipient (\$1,720). This reflects, in part, (1) the higher direct care costs of serving the habilitation and health needs of retarded persons with more severe disabilities, and (2) the historic dependency (though it is now diminishing) of States on the large, expensive, public institutions as the vehicle for delivering ICF/MR services.

Table 6 - Medicaid recipients, payments, and payments per recipient, by area of jurisdiction: Fiscal year 1985

- The average payment per Medicaid recipient ranged by State from a low of \$819 in West Virginia to a high of \$3,384 in New York (Figure 4).
- Although California led the Nation with 3.4 million recipients in FY 1985, the average cost per recipient was \$1,197, 44 percent less than the national average of \$1,720.
- New York and California accounted for 31 percent of all Medicaid vendor payments and 26 percent of all recipients.

Table 4

Percent distribution of Medicaid recipients and payment, and average payment per recipient, by maintenance assistance status and basis of eligibility: Fiscal year 1985

Basis of eligibility	Recipients			Payments			Average payment per recipient		
	Maintenance assistance status			Maintenance assistance status			Maintenance assistance status		
	Total	Percent distribution		Total	Percent distribution		Total	Percent distribution	
		Cash assistance	Medical assistance only		Cash assistance	Medical assistance only		Cash assistance	Medical assistance only
Total	100.0	73.2	26.8	100.0	51.5	48.5	\$1,720	\$1,210	\$3,113
Age 65 or over	100.0	54.3	45.7	100.0	24.9	75.1	4,605	2,112	7,567
Blind	100.0	88.2	11.8	100.0	69.4	30.6	3,113	2,437	8,444
Disabled	100.0	78.1	21.9	100.0	60.9	39.1	4,497	3,507	8,028
Dependent children under age 21	100.0	83.6	16.4	100.0	82.5	17.5	453	447	483
Adults in families with dependent children	100.0	78.5	21.5	100.0	83.4	16.6	860	914	664
Other Title XIX	100.0	0.0	100.0	100.0	0.0	100.0	657	0	657

NOTE: The sum of recipients exceeds total recipients because recipients who are eligible in more than one category are counted in each category, but only once in the total.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 5

Medicaid recipients, payments, percent of payments, and payment per recipient, by type of service:

Fiscal year 1985

Type of service	Recipients in thousands	Payments in millions	Percent of payments	Payment per recipient
Total	21,808	\$37,508	100.0	\$1,720
Inpatient hospital 1/	3,494	10,645	28.4	3,047
Physician	14,387	2,346	6.3	163
Outpatient	10,072	1,789	4.8	178
Skilled nursing facility	547	5,073	13.5	9,280
Intermediate care facility (ICF)				
ICF/MR 2/	146	4,719	12.6	32,320
ICF, all other	829	6,526	17.4	7,872
Home health	535	1,120	3.0	2,092
Prescribed drugs	13,920	2,315	6.2	166
Other 3/	23,472	2,975	7.9	127

1/ Includes mental hospitals.

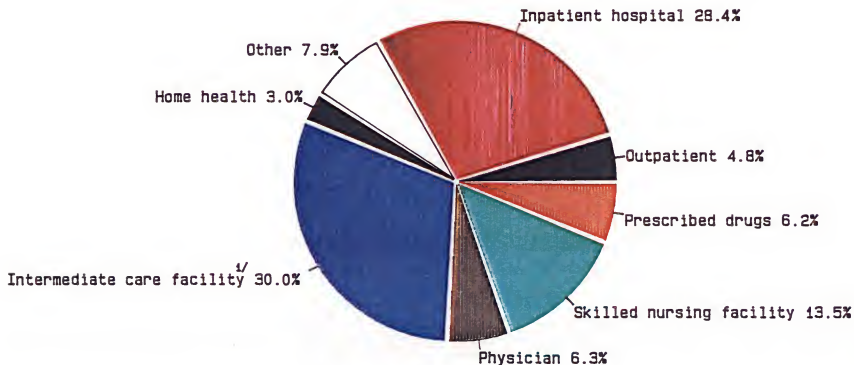
2/ Intermediate care facility for the mentally retarded.

3/ Includes dental, other practitioner, clinic, laboratory, radiology, family planning, and other services.

NOTE: Recipients may receive more than one type of service, but are only counted once in the total.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Figure 3
Percent distribution of Medicaid payments,
by type of service: Fiscal year 1985



Total Medicaid payments - \$37.5 billion

1/ Includes intermediate care facilities (ICF's) for the mentally retarded (ICF/MR) and all other ICF's.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 6

Medicaid recipients, payments, and payments per recipient, by area of jurisdiction: Fiscal year 1985

Area of jurisdiction	Number of recipients in thousands	Payments in millions	Payment per recipient
All areas	21,808	\$37,508	\$1,720
Alabama	316	375	1,187
Alaska	24	67	2,768
Arkansas	197	358	1,816
California	3,381	4,045	1,197
Colorado	147	316	2,144
Connecticut	217	595	2,736
Delaware	41	71	1,738
District of Columbia	98	298	3,029
Florida	562	943	1,678
Georgia	469	760	1,620
Hawaii	92	140	1,522
Idaho	39	76	1,965
Illinois	1,063	1,653	1,554
Indiana	284	747	2,630
Iowa	212	360	1,698
Kansas	142	256	1,809
Kentucky	408	540	1,322
Louisiana	416	725	1,743
Maine	124	232	1,868
Maryland	329	584	1,776
Massachusetts	523	1,433	2,739
Michigan	1,133	1,517	1,338
Minnesota	357	1,001	2,802
Mississippi	300	274	916
Missouri	356	525	1,474
Montana	47	96	2,013
Nebraska	94	167	1,779
Nevada	28	66	2,328
New Hampshire	38	118	3,129
New Jersey	581	1,145	1,969
New Mexico	87	148	1,698
New York	2,242	7,588	3,384
North Carolina	343	647	1,884
North Dakota	37	117	3,183
Ohio	1,045	1,767	1,691
Oklahoma	270	460	1,706
Oregon	153	239	1,565
Pennsylvania	1,071	1,797	1,678
Rhode Island	101	250	2,482
South Carolina	238	309	1,302

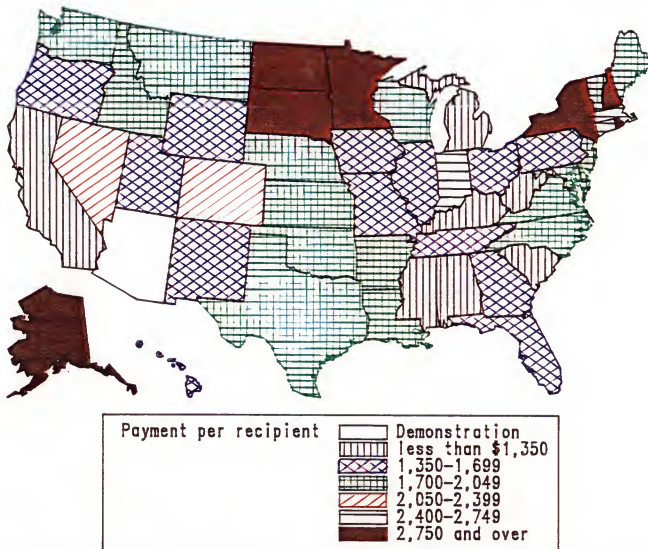
Table 6 - continued

Medicaid recipients, payments, and payments per recipient, by area of jurisdiction: Fiscal year 1985

Area of jurisdiction	Number of recipients in thousands	Payments in millions	Payment per recipient
South Dakota	34	94	2,790
Tennessee	362	578	1,596
Texas	761	1,414	1,857
Utah	72	110	1,519
Vermont	50	89	1,775
Virginia	303	547	1,805
Washington	326	584	1,789
West Virginia	211	173	819
Wisconsin	473	942	1,991
Wyoming	20	28	1,444
Puerto Rico	1,572	139	89
Virgin Islands	17	4	249

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Figure 4
Medicaid: Average payment per recipient, by area of jurisdiction: Fiscal year 1985



NOTES: National average: \$1,720. Arizona participates solely under a Health Care Financing Administration demonstration project.
SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Appendix A

Basic service coverage

All States participating in Medicaid must cover the following basic services for all categorically needy recipients:

- Inpatient hospital services, except services in an institution for tuberculosis or mental disease, that are provided for the care and treatment of inpatients under the direction of a physician or dentist. Hospitals must be licensed or formally approved by a designated State authority. In addition, approval is granted to any hospital certified to participate under Medicare.
- Outpatient hospital services that generally include any preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by or under the direction of a physician or dentist. The hospital must meet the same requirements as for inpatient services.
- Rural health clinic services in certified clinics furnished by a physician or by a physician's assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner.
- Other laboratory and X-ray services including professional and technical laboratory and radiological services ordered by physicians or other licensed practitioners, within the scope of their practices as defined by State law. These services are provided by or under the direction of physicians or other licensed practitioners in locations other than a hospital outpatient department or clinic.
- To the extent that State laws or regulations authorize nurse midwives to practice, nurse-midwife services concerned with management of the care of mothers and newborns.
- Skilled nursing facility (SNF) services for individuals 21 years of age and over other than services in an institution for tuberculosis or mental disease. These services must be ordered by and provided under the direction of a physician in a certified participating facility.
- Physicians' services, whether provided in the office, the patient's home, a hospital, a SNF, or elsewhere. Physicians' services must be within the scope of practice of the profession as defined by State law, and are provided by or under the supervision of a doctor licensed to practice medicine or osteopathy by the State.
- Early and periodic screening, diagnosis and treatment (EPSDT) for recipients under age 21 that must include screening and diagnostic services to determine physical or mental defects and provide health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.

- Family planning services and supplies for women of childbearing age who are eligible for Medicaid and desire such services and supplies.
- Home health care for persons authorized by a physician to receive skilled nursing services provided in the patient's residence by a licensed agency. These include nursing services provided on a part-time or intermittent basis by a home health agency (or by a registered nurse when there is no home health agency in the area); home and medical supplies, equipment, and appliances suitable for use in the home.

Appendix B

Optional service coverage

Each State may offer coverage of certain optional services under Medicaid that may include:

- Medical or other remedial care provided by licensed practitioners within the scope of practice as defined under State law. These practitioners may include, among others, chiropractors (limited coverage), optometrists, and podiatrists.
- Home health services specifically included are physical therapy, occupational therapy, speech pathology, and audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services.
- Private-duty nursing services provided by a professional registered nurse or a licensed practical nurse under the general direction of the patient's physician. Services may be provided in the patient's home or in a hospital or SNF when the patient requires individual and continuous care beyond that available from a visiting nurse or that is provided routinely by the nursing staff of the hospital or SNF.
- Clinic services, including preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services. These services must be furnished by or under the direction of a physician or dentist in a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients.
- Dental services in addition to those required to be provided to persons under 21 years of age in the State's EPSDT program.
- Physical therapy and related services, occupational therapy, and supplies and equipment needed for individuals with speech, hearing, and language disorders. These services must be furnished by or under the supervision of individuals qualified (licensed, registered, or certified, as appropriate) in the practice of the appropriate profession, and under the prescription or referral of a physician.

- Prescribed drugs, dentures, prosthetic devices, orthopedic shoes, and eyeglasses.
- Diagnostic, screening, preventive, and rehabilitative services.
- Inpatient hospital services, SNF services, and intermediate care facility (ICF) services to persons 65 years of age and over in institutions for tuberculosis or mental disease.
- ICF services, other than services in an institution for tuberculosis or mental disease, for the physically ill or mentally retarded.
- Inpatient psychiatric services for persons under age 21.
- Other medical or remedial care recognized under State law. Such additional items and services include (1) transportation, (2) emergency hospital services, (3) nonprofessional personal care services prescribed by a physician and performed under the supervision of a registered nurse in the home, (4) Christian Science sanatoriums and nursing services, and (5) SNF services for persons under 21 years of age.

Definitions of terms

Basis of eligibility:

Aged, blind, and disabled - For these groups, the Medicaid program uses eligibility criteria comparable to the Supplemental Security Income eligibility requirements for cash benefits under Title XVI of the Social Security Act.

Aid to families with dependent children (AFDC) - In general, families with dependent children are families with one parent dead, absent, or incapacitated and two-parent families with an unemployed or underemployed father. Children may become eligible if they are under age 21, dependent children, and members of a family with dependent children. Individuals under 21 years of age who qualify as caretaker relatives are considered adults. Adults become eligible only if they are caretaker relatives. Eligible adults may include any blood relative, stepparent, stepbrother, or stepsister. In addition, a person who legally adopts a child, or an adoptor's spouse, parent, or relative may be deemed eligible.

Other Title XIX individuals - Individuals in this group meet AFDC income and resource limits but do not meet the definition of a dependent child under the AFDC program.

Sources and limitations of data

The data represent a compilation of the annual Medicaid reports submitted by the State Medicaid Agencies on the HCFA-2082 statistical report form. States obtain this information from their Medicaid claims processing and payment operations. Hence, the data reported for fiscal years 1984 and 1985 represent bills paid during each respective year.

In past years, States that did not submit the HCFA-2082 report looked to HCFA to help them produce data in the form of estimates. State data have been estimated by using weighted linear extrapolation methods or by aggregating data from monthly reports. In addition, information supplied by the States in prior years has been used to correct previous estimates of unreported data. However, estimates for States that did not submit a HCFA-2082 report in more recent years were derived from the HCFA-64 Quarterly Financial Report and prior year data. Selected sections of the HCFA-2082 report from New York and Puerto Rico were estimated for fiscal year 1985.

A recipient who receives services under more than one basis of eligibility will be reported under each eligibility group, but only once in the total.

Data presented throughout this Brief have been rounded for display purposes but the percentages are based on the actual numbers. Hence, when using the rounded numbers to verify percentages, one may get a slightly different result.

For data presentation, all jurisdictions include 49 States, the District of Columbia, Puerto Rico, and the Virgin Islands.

Acknowledgments

During the review process of this report, significant contributions were made by William Lasowski of the Bureau of Program Operations and Kathleen Blume and Bernie Truffer of the Bureau of Eligibility, Reimbursement and Coverage. A substantial portion of the background material contained in this Brief was based on information in the Health Care Financing Program Statistics Medicare and Medicaid Data Book, 1984. The authors are Martin Ruther, Valerie Rinkle, Aileen Pagan-Berlucchi, and Joanne Yanek.

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